PRINTED: 06/04/2018 FORM APPROVED OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ′ | | CONSTRUCTION | | PLETED |
|--|--|--|--------------|-----|--|------|-----------------------|
| | | 345113 | B. WING | | | | C / 26/2018 |
| NAME OF PR | ROVIDER OR SUPPLIER | | | S | TREET ADDRESS, CITY, STATE, ZIP CODE | | |
| | | | | 24 | 401 WAYNE MEMORIAL DRIVE | | |
| WILLOW | CREEK NURSING AND R | EHABILITATION CENTER | | | OLDSBORO, NC 27534 | | |
| (X4) ID | | ATEMENT OF DEFICIENCIES | ID | | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX TAG | | Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | PREFI TAG | | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | | COMPLETION DATE |
| F 558 SS=D | | odations Needs/Preferences | F | 558 | | | 5/14/18 |
| | services in the facility accommodation of re- preferences except w | sident needs and hen to do so would | | | | | |
| | other residents. | or safety of the resident or is not met as evidenced | | | | | |
| | Based on record revi | ew and staff interviews the | | | F558 | | |
| | facility failed to provide a bath for 1 of 1 residents (Resident #2). Findings included: | | | | Reasonable Accommodations Needs/Preferences CFR(s): 483.10 (e) (3) | | |
| | 04/06/18 revealed Re | m Data Set (MDS) dated ssident #2 was readmitted to | | | | | |
| | included anoxic brain | 7. Diagnoses on the MDS damage, respiratory failure, Resident #2 had short and | | | The process that lead to the deficiency was based on record review and staff interviews the facility failed to provide a | | |
| | long term memory pro | oblems and was severely sion making. Resident #2 | | | bath for 1 of 1 residents (resident #2). | • | |
| | | t on one person for bathing. | | | 100% audit of all residents□ bathing documentation, to include resident #2, | for | |
| | | /pe record dated 04/18/18 station that a bath was given ay. | | | April 2018 by the Assistant Director of Nursing (ADON), the Quality Improvem (QI) nurses and the RN supervisor to ensure baths are being provided, in | nent | |
| | | 2's Care Plan revised ocus on assistance for | | | addition to any other care assigned on shower/bath days, including nail care a | und | |
| | bathing related to hyp | | | | hair washing was initiated on 5/3/2018. | | |
| | | al through the next review | | | Any areas of concern identified during t | | |
| | | o be neat, clean and odor | | | audit will be immediately addressed by | | |
| | | cluded bed baths, and to | | | Director of Nursing (DON) to include | • | |
| | | vashed and nails were | | | additional training of staff and will be | | |
| | manicured on Wedne | sdays. | | | completed by 5/3/2018. | | |
| | | 25/18 at 8:17 AM Nursing | | | 100% in-service for all licensed nurses | | |
| | Assistant (NA) #2 sta | | | | and nursing assistants (NA) to include | | |
| | <u> </u> | t it was documented in the | | | agency, was initiated by the Staff | | |
| ADODATODY | DIDECTORIC OD DDOVIDEDIO | SUPPLIER REPRESENTATIVE'S SIGNATURE | _ | | TITI F | | (X6) DATE |

05/14/2018

Electronically Signed

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | IDENTIFICATION NUMBED: | | | ONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
|---|---|---|---------------------|-----|---|--|----------------------------|
| | | 345113 | B. WING _ | | | | C 26/2018 |
| NAME OF PI | ROVIDER OR SUPPLIER | | | STF | REET ADDRESS, CITY, STATE, ZIP CODE | 1 | |
| MILL 014/ | ODEEK MUDOMO AND I | DELIA DII ITATIONI GENTER | | 240 | 1 WAYNE MEMORIAL DRIVE | | |
| WILLOW | CREEK NURSING AND F | REHABILITATION CENTER | | GO | LDSBORO, NC 27534 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFI) TAG | × | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | | (X5) COMPLETION DATE |
| F 558 | In a telephone intervi NA #4 stated she had Resident #2 on 04/18 been on her way to be was called to the Dire office. She stated she provide a bath to Resident to provide enough staff to provide residents on the 700. In an interview on 04 indicated Resident #2 She stated Resident #2 She stated Resident bathed daily an odor. In an interview on 04 stated she expected choice of the resident the needs of the resident. | e. She indicated Resident #2 raff for bathing. liew on 04/25/18 at 1:05 PM d been assigned to care for 8/18. She indicated she had been assigned to care for 8/18. She indicated she had been the resident #2 when she bector of Nursing's (DON) he had been unable to sident #2 as required prior to because there was not de the needed care to the hall. 1/25/18 at 3:25 PM Nurse #5 2 received a daily bed bath. 1/26/18 at 4:30 PM the DON care to be provided per the t, the responsible party, or dent. She indicated that pire a lot and that a daily | F | | Facilitator on 5/2/2018, regarding providing all residents with showers or baths based on the resident preference addition to any other care assigned on shower/bath days, including nail care a hair washing. The showers must includ documentation in the electronic medica record Point Click Care (PCC) and Point Care (POC) to show that the shower/bath was provided. If a resident refuses, the nurse will be notified in ord that the refusal will be documented in the resident progress note by the licens nurse and will be completed by 5/3/2011. 10% of all residents documentation in PCC and POC will be reviewed by the ADON, the QI nurse and the RN supervisor to ensure showers/ baths and documented to include any additional cassigned on shower/bath days, such an anil care and hair washing, and refusal will be documented in the progress not by the licensed nurse, weekly for 8 weethen monthly for 1 month utilizing a Shower Documentation audit tool. Any areas of concern identified during the audit will be immediately addressed by ADON, the QI nurse and/or the RN supervisor to include additional staff training. The Director of Nursing (DON) will review and initial the Shower Documentation audit tool weekly for 8 weeks and then monthly for one monther addressed. The administrator will review and presentation audit review and presentation were addressed. | e, in and de de al int t der he ed 18. The care s de de the eks, the he the | |
| | | | | | The administrator will review and presente findings of the Shower Documentation | | |

| | DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | CONSTRUCTION | (X3) DATE COMP | SURVEY |
|--------------------------|--|---|---------------------|------|--|-------------------|----------------------------|
| | | 345113 | B. WING | | | 1 | C 26/2018 |
| | ROVIDER OR SUPPLIER CREEK NURSING AND F | REHABILITATION CENTER | | 24 | REET ADDRESS, CITY, STATE, ZIP CODE 101 WAYNE MEMORIAL DRIVE OLDSBORO, NC 27534 | 1 04/ | 20/2010 |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFII TAG | x | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | | (X5) COMPLETION DATE |
| F 558 | Continued From page | e 2 | F | 5558 | audit tool to the Executive QI committee monthly for 3 months. Any issues, concerns, and/or trends identified will be addressed by implementing changes a necessary, to include continued freque of monitoring. The Administrator and the DON will be responsible for the implementation of corrective actions to include all 100% audits, in services, and monitoring related to the plan of correction. | pe s ncy | |
| F 580 SS=D | S483.10(g)(14) Notificity A facility must immonsult with the residence consistent with his or representative(s) who (A) An accident involvesults in injury and head to | cation of Changes. lediately inform the resident; ent's physician; and notify, her authority, the resident en there is- ving the resident which las the potential for requiring n; lige in the resident's physical, lial status (that is, a n, mental, or psychosocial reatening conditions or); eatment significantly (that is, e an existing form of lerse consequences, or to m of treatment); or sfer or discharge the | | 580 | | | 5/14/18 |

| | DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | A. BUILE | | E CONSTRUCTION | (X3) DATE S COMPLI | ETED |
|--------------------------|--|--|-------------------|-----|---|-----------------------|----------------------------|
| | | 345113 | B. WING | | | O4/2 | 6/2018 |
| | ROVIDER OR SUPPLIER CREEK NURSING AND | REHABILITATION CENTER | ' | 2 | TREET ADDRESS, CITY, STATE, ZIP CODE 401 WAYNE MEMORIAL DRIVE GOLDSBORO, NC 27534 | 1 04/2 | 0/2010 |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | ID PREF TAG | IX | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 580 | physician. (iii) The facility must resident and the resiwhen there is- (A) A change in roomas specified in §483 (B) A change in residual state law or regulative (e) (10) of this section (iv) The facility must update the address phone number of the representative(s). §483.10(g)(15) Admission to a compathat is a composite of §483.5) must disclosits physical configurations that compropart, and must specific room changes between the section of the representative (9). Based on record regulative and sent to the labor sampled residents (If urinary tract infection included: Review of the admiss (MDS) dated 10/12/2 cognitively intact. Reart failure, Chronic Disease (COPD), and | also promptly notify the ident representative, if any, in or roommate assignment .10(e)(6); or dent rights under Federal or ons as specified in paragraph in. record and periodically (mailing and email) and eresident cosite distinct part. A facility distinct part (as defined in se in its admission agreement ation, including the various ise the composite distinct ify the policies that apply to een its different locations. T is not met as evidenced view and staff and physician was not obtained for analysis ratory as ordered for 1 of 1 Resident #1) with recurring in (UTI) symptoms. Findings | | 580 | F580 Notify of Changes (Injury/Decline/Roo etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) The process that lead to the deficiency was based on record review and staff physician interviews the facility failed to notify the physician that a urine sample was not obtained for analysis and sense the laboratory as ordered for 1 of 1 sample residents (resident #1) with recurring urinary tract infection (UTI) | y and co e | |
| ORM CMS-256 | 7(02-99) Previous Versions Ob | osolete Event ID: ID | W111 | Fa | cility ID: 923020 If conti | inuation sheet | Page 4 of 30 |

PRINTED: 06/04/2018 FORM APPROVED OMB NO. 0938-0391

| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ′ | 2) MULTIPLE CONSTRUCTION BUILDING | | | (X3) DATE SURVEY COMPLETED | |
|--------------------------|--|--|---|--|---|--------------------------------------|-------------------------------|--|
| | | 345113 | B. WING _ | | | | C 26/2018 | |
| NAME OF P | ROVIDER OR SUPPLIER | | <u> </u> | ST | TREET ADDRESS, CITY, STATE, ZIP CODE | 1 04/ | 20/2010 | |
| | | | | | 101 WAYNE MEMORIAL DRIVE | | | |
| WILLOW | CREEK NURSING AND F | REHABILITATION CENTER | | GOLDSBORO, NC 27534 | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFI) TAG | x | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | | (X5) COMPLETION DATE | |
| F 580 | Continued From pag | e 4 | F 5 | 580 | | | | |
| | | #1's Care Plan created terventions of: observe for | | | symptoms. Resident #1 no longer resi in the facility. | des | | |
| | signs and symptoms | of UTI and notify physician ion, obtain labs as ordered | | | A 100% review of all residents progres notes will be completed by the Assistan Director of Nursing (ADON), the Qualit Improvement (QI) nurses and/or RN | nt | | |
| | Resident #1 was re-admitted to the facility from the hospital on 11/27/17 with diagnoses of UTI and an acute exacerbation of COPD. supervisor, was initiated on 5 ensure appropriate documen include, that the resident phy | | supervisor, was initiated on 5/3/2018), ensure appropriate documentation, to include, that the resident physician and resident representative (RR) has been | t | | | | |
| | dated 12/03/17 at 9:4 #1 had complained of | /Post-Acute nursing note I7 AM revealed that Resident If a burning sensation on Physician had been made | | | notified of any significant change in resident □s condition to include when la are ordered and the labs are unable to obtained, for the last 30 days, 4/3/2018 5/3/2018. | abs be | | |
| | revealed an order for and sensitivity (C&S) Review of the medica | al record from vealed no results for the | | The resident s physician and/or RR will be notified of any identified areas of concern and the notification will be documented in the resident s electronic medical record by the Assistant Director of Nursing (ADON), the Quality Improvemer (QI) nurses and/or RN supervisor, and will be completed by 6/3/2018 utilizing a | | nic or of nent | | |
| | 12/03/17 at 10:42 PN attempted to obtain a unsuccessful. The n would make the once Resident #1's burning Review of the Skilled dated 12/09/17 at 10 had been given for a | /Post-Acute nursing note :54 AM revealed an order UA with C&S. | | | resident census. An inservice was initiated for 100% of licensed nurses, to include nurse #1 ar #2 and #5, to include agency nurses, c 5/3/2018 by the Staff Facilitator regard notification of physician and/or RR of a significant change in resident □s condit to include when labs are ordered and t labs are unable to be obtained and that documentation of notification to be | nd on ing iny tion he | | |
| | dated 12/11/17 at 7:5 | /Post-Acute nursing note 58 PM revealed Resident #1 tion and an order had been | | | entered into the resident s medical record, will be completed by 5/4/2018. | | | |

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| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 ' ' | | CONSTRUCTION | (X3) DATE COMP | SURVEY PLETED |
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| | | 345113 | B. WING _ | | | | 26/2018 |
| NAME OF PI | ROVIDER OR SUPPLIER | ı | | S | TREET ADDRESS, CITY, STATE, ZIP CODE | , | 20.20.0 |
| | | | | 24 | 401 WAYNE MEMORIAL DRIVE | | |
| WILLOW | CREEK NURSING AND R | REHABILITATION CENTER | | G | OLDSBORO, NC 27534 | | |
| (X4) ID | SUMMARY ST | ATEMENT OF DEFICIENCIES | ID | | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PRÉFIX TAG | , | Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | PREFI TAG | X | (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | | COMPLETION DATE |
| F 580 | Continued From page | e 5 | F | 580 | | | |
| | given for a UA with C | &S. | | | When there is any significant change ir | 1 | |
| | | | | | resident⊡s condition, to include when I | | |
| | Review of the Skilled | /Post-Acute nursing note | | | are ordered and the labs are unable to | be | |
| | dated 12/12/17 at 3:1 | 7 AM revealed the nurse | | | obtained, the license nurse is responsi | ble | |
| | was waiting to have t | he UA and C&S done. | | | for notifying the resident physician and | or/ | |
| | | | | | RR and documenting in the residents | | |
| | | /24/18 at 3:38 PM Nurse #1 | | | electronic medical records. The ADON | | |
| | | sident #1 on 12/03/17 stated | | | nurses and the RN supervisor will revie | | |
| | · · | led of burning on urination | | | 10% of residents progress notes, daily | | |
| | | fy the physician and get an &S. She indicated when the | | | times a week for 4 weeks then weekly weeks then monthly x 1 month to ensu | | |
| | | the facility the physician | | | appropriate documentation for notificat | | |
| | | the result. Nurse #1 stated | | | of the physician and/or RR, for any | 1011 | |
| | | collect urine from Resident | | | changes in the resident, to include whe | en | |
| | • | successful. She indicated | | | labs are ordered and the labs are unab | | |
| | | oming nurse that the urine | | | to be obtained, is recorded in the residence | | |
| | | She stated she did not | | | medical record utilizing a MD/RR | | |
| | follow-up to make sur | re the urine sample had | | | notification QI Audit Tool. The ADON, O | QΙ | |
| | been collected and se | ent to the laboratory. She | | | nurses and the RN supervisor, will | | |
| | | otified the physician that she | | | immediately notify the MD/RR for any | | |
| | had been unable to c | ollect the urine sample. | | | identified areas of concern and docume | | |
| | | | | | in the clinical record and provide retrain | ning | |
| | | /25/18 at 1:55 PM the | | | with the license nurse. The DON will | | |
| | | OON) verified that no urine | | | review and initial the RR/MD notificatio | n | |
| | | nt to the laboratory for | | | QI Audit Tool weekly x 8 weeks then | | |
| | analysis as requested 12/03/17. | by the physician on | | | monthly x 1 month for completion and the ensure all areas of concern were | .0 | |
| | 12/03/17. | | | | addressed and documented in the | | |
| | In an interview on 04 | /25/18 at 3:05 PM Nurse #3 | | | electronic medical records and retraining | na | |
| | | ent #1 on 12/09/17 stated | | | provided with the responsible staff | · J | |
| | | r getting an order for a | | | member. | | |
| | | g a urine sample from | | | | | |
| | | viewing her note from | | | The Executive QI committee will meet | | |
| | 12/09/17 she indicate | ed she must have received | | | monthly and review the MD/RR | | |
| | the information in rep | ort but that she did not call | | | notification QI Audit Tool to make chan | ges | |
| | the physician or obtai | in the urine sample. | | | as needed, to include continued freque of monitoring x 3 months. | ncy | |
| | In an interview on 04 | /25/18 at 3:25 PM Nurse #5 | | | | | |
| | stated if she was una | ble to collect a urine sample | | | The Administrator and the DON will be | | |

| | DF DEFICIENCIES CORRECTION | I DENTIFICATION NUMBER: | | PLE CONSTRUCTION | \ , , | (X3) DATE SURVEY COMPLETED | |
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| | | 345113 | B. WING | | 04/3 | 26/2018 | |
| NAME OF P | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE | 04/2 | 20/2010 | |
| MII I 0M/ | DEEK NUDONO AND E | STUARU ITATION OFNITER | | 2401 WAYNE MEMORIAL DRIVE | | | |
| WILLOW | CREEK NURSING AND R | EHABILITATION CENTER | | GOLDSBORO, NC 27534 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY) | OULD BE | (X5) COMPLETION DATE | |
| F 580 | for a catheterized spe would document and know that a sample w indicated she would o sure the sample had the laboratory. Nurse collected she would g | ohysician and get an order ecimen. If still unable she let the oncoming nurse was still needed. She check the next day to make been collected and sent to e #5 stated if it had not been to the of the supervisor and of give him the opportunity to | F 58 | responsible for the implementation corrective actions to include all 10 audits, in services, and monitoring to the plan of correction. | 00% | | |
| | In an interview on 04/25/18 at 5:09 PM Nurse #2 stated she was assisting Nurse #1 with charting on 12/11/17. She indicated Resident #1 told her during her assessment that she had been having burning on urination. Nurse #2 informed Nurse #1 and Nurse #1 told her she would call the physician and obtain an order for the urine test. Nurse #2 stated she did not call the physician to inform him of Resident #1's symptoms or that the previously ordered laboratory tests had not been completed. She indicated someone should have followed up on the missing urinalysis from 12/03/17 and notified the physician. In a telephone interview on 04/26/18 at 3:43 PM Resident #1's physician stated he expected his orders to be followed. He indicated the facility | | | | | | |
| | results of the laborator indicated he did not ke expected to be notified not be completed so explored. In a follow-up interviet the DON stated it was for laboratory tests be | out notifying him of the bry tests he ordered. He now what happened but he dif laboratory tests could other options could be w on 04/26/18 at 4:15 PM is her expectation that orders be completed as ordered. In e should have followed-up | | | | | |

| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULT A. BUILDI | | CONSTRUCTION | (X3) DATE COMF | SURVEY PLETED |
|--------------------------|--|---|------------------------|-----|--|-------------------|----------------------------|
| | | 345113 | B. WING _ | | | | C 26/2018 |
| | ROVIDER OR SUPPLIER CREEK NURSING AND F | REHABILITATION CENTER | | 240 | REET ADDRESS, CITY, STATE, ZIP CODE 11 WAYNE MEMORIAL DRIVE 12 DLDSBORO, NC 27534 | • | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFI TAG | × | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | | (X5) COMPLETION DATE |
| F 580 | Continued From page | ⊋ 7 | F t | 580 | | | |
| F 656 | physician that the tes Resident #1 continue Develop/Implement C | d C&S and notified the ts were not done and that d to have UTI symptoms. Comprehensive Care Plan | F | 356 | | | 5/14/18 |
| SS=D | implement a compreh care plan for each res resident rights set for §483.10(c)(3), that in objectives and timefra medical, nursing, and needs that are identif assessment. The condescribe the following (i) The services that a or maintain the reside physical, mental, and required under §483. (ii) Any services that under §483.24, §483. provided due to the reunder §483.10, include treatment under §483 (iii) Any specialized s rehabilitative services provide as a result of recommendations. If findings of the PASAF rationale in the reside (iv)In consultation wit resident's representa (A) The resident's good desired outcomes. | cility must develop and mensive person-centered sident, consistent with the th at §483.10(c)(2) and cludes measurable ames to meet a resident's mental and psychosocial ied in the comprehensive mprehensive care plan must g-are to be furnished to attain ent's highest practicable psychosocial well-being as 24, §483.25 or §483.40; and would otherwise be required a.25 or §483.40 but are not esident's exercise of rights ding the right to refuse 8.10(c)(6). ervices or specialized as the nursing facility will PASARR a facility disagrees with the RR, it must indicate its ent's medical record. In the resident and the tive(s)-als for admission and eference and potential for | | | | | |

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| | | 345113 | B. WING _ | | | 04/2 | C 26/2018 |
| NAME OF PR | ROVIDER OR SUPPLIER | | | S | TREET ADDRESS, CITY, STATE, ZIP CODE | | |
| WILLOW (| DEEK NIIDSING AND E | REHABILITATION CENTER | | 2 | 401 WAYNE MEMORIAL DRIVE | | |
| WILLOW | REEK NURSING AND F | REHABILITATION CENTER | | C | GOLDSBORO, NC 27534 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | x | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | | (X5) COMPLETION DATE |
| F 656 | Continued From page | e 8 | F 6 | 356 | | | |
| | whether the resident' | 's desire to return to the | | | | | |
| | community was asse | essed and any referrals to | | | | | |
| | local contact agencie | es and/or other appropriate | | | | | |
| | entities, for this purpo | | | | | | |
| | | in the comprehensive care | | | | | |
| | | in accordance with the | | | | | |
| | requirements set fort section. | h in paragraph (c) of this | | | | | |
| | | T is not met as evidenced | | | | | |
| | by: | i is not met as evidenced | | | | | |
| | | riew and staff and physician | | | F656 | | |
| | | failed to implement the | | | Develop/Implement Comprehensive Ca | ıre | |
| | comprehensive Care | Plan for 1 of 1 residents | | | Plan | | |
| | | gated for Urinary Tract | | | CFR(s): 483.21(b)(1) | | |
| | | espiratory medications. | | | | | |
| | Findings included: | | | | | | |
| | Davious of the admiss | nion Minimum Data Cat | | | The process that lead to the deficiency | n d | |
| | | sion Minimum Data Set 7 revealed Resident #1 was | | | was based on record review and staff a physician interviews the facility failed to | - | |
| | | y with diagnoses of Chronic | | | implement the comprehensive care plan | | |
| | | ry Disease (COPD), heart | | | for 1 of 1 residents (resident #1) | | |
| | | illation. Resident #1 was | | | investigated for Urinary tract infections | | |
| | frequently incontinen | | | | (UTI) and respiratory medications. | | |
| | cognitively intact. | | | | Resident #1 no longer resides in the | | |
| | | | | | facility. | | |
| | | nt #1's Care Plan initiated | | | D-4A | | |
| | | focus on occasional urinary | | | Part A | | |
| | | to decreased mobility and ensation. Interventions | | | A 100% review of all residents progre notes will be completed by the Assistan | | |
| | | for signs of UTI and to notify | | | Director of Nursing (ADON), the Quality | | |
| | the physician for pos | - | | | Improvement (QI) nurses and/or RN | · | |
| | | erved. Interventions also | | | supervisor, was initiated on 5/3/2018), | to | |
| | | poratory results as ordered | | | ensure appropriate documentation, to | | |
| | | sician of abnormal findings. | | | include, that the resident physician and | | |
| | | | | | resident representative (RR) has been | | |
| | | /25/18 at 1:55 PM the | | | notified of any significant change in | | |
| | • , | DON) verified that a urine | | | resident □s condition to include when la | bs | |
| | • | sent to the laboratory for | | | are ordered, to include urine for | | |
| | analysis by the facilit | y in December 2017 as | | | complaints of burning on urination in | | |

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| | | | |) DATE SURVEY COMPLETED | | |
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| NAME OF P | ROVIDER OR SUPPLIER | | <u> </u> | STREET ADDRESS, CITY, STATE, ZIP COD | | -1/20/2010 |
| | | | | 2401 WAYNE MEMORIAL DRIVE | | |
| WILLOW | CREEK NURSING AND | REHABILITATION CENTER | | GOLDSBORO, NC 27534 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | SHOULD BE | (X5) COMPLETION DATE |
| F 656 | Continued From pag | ge 9 | F 6 | 56 | | |
| | requested by the ph | | | accordance with the resident | care plan. | |
| | requestion by and pro- | , 5.5.6 5 | | and when the labs are unable | | |
| | In an interview on 04 | 4/26/18 at 3:24 PM the MDS | | obtained for the last 30 days, | | |
| | Coordinator stated to | he Care Plan was a very | | 5/3/2018. The resident □s phy | | |
| | | Resident's plan of care. She | | and/or RR will be notified of a | | |
| | indicated the Care F | Plan directed what care the | | areas of concern and the noti | fication will | |
| | resident needed and | that it was a problem if the | | be documented in the residen | ıt□s medical | |
| | Care Plan was not for | ollowed. | | record by the Assistant Direct | | |
| | | | | (ADON), the Quality Improver | | |
| | • | view on 04/26/18 at 3:43 PM | | nurses and/or RN supervisor, | | |
| | | cian stated he expected to be | | completed by 6/3/2018 utilizing | ig a resident | |
| | | tests were not collected so | | census. | 4000/ of all | |
| | other options could I | oe explorea. | | An inservice was initiated for | | |
| | In an interview on 0 | 4/26/18 at 4:15 PM the DON | | licensed nurses, to include nu #3 and #5, to include agency | | |
| | | the Care Plan to be followed. | | 5/3/2018 by the Staff Facilitate | | |
| | | xpected all treatments and | | when there is any significant of | | |
| | | e completed and that care be | | resident □s condition, to include | - | |
| | _ | lents as directed by the Care | | are ordered, to include urine f | | |
| | Plan and the physici | - | | complaints of burning on urina | ation in | |
| | | | | accordance with the residents | s care plan, | |
| | B. Review of Reside | ent #1's Care Plan initiated | | and the labs are unable to be | obtained, | |
| | | focus on a potential for | | the license nurse is responsib | | |
| | _ | patterns related to COPD | | notifying the resident physicia | | |
| | _ | t failure (CHF). Interventions | | and documenting in the reside | | |
| | included the adminis | | | electronic medical records an | d will be | |
| | treatments as ordere | ed by the physician. | | completed by6/3/20018. | | |
| | Review of the 11/27 | /17 and the December 2017 | | The ADON, QI nurses and the | e RN | |
| | | ration Record (MAR) | | supervisor will review 10% of | | |
| | revealed Duoneb via | a nebulizer every 4 hours was | | progress notes, daily 3 times | | |
| | not administered. | | | weeks then weekly x 4 weeks | | |
| | | | | monthly x 1 month to ensure a | | |
| | | 4/26/18 at 3:24 PM the MDS | | documentation for notification | | |
| | | he Care Plan was a very | | physician and/or RR, for any | - | |
| | | Resident's plan of care. She | | the resident, to include when | | |
| | | Plan directed what care the | | ordered, to include urine for c | • | |
| | | that it was a problem if the | | burning on urination in accord | | |
| | Care Plan was not for | Dilowed. | 1 | the residents care plan, and t | me labs are | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | , , , | E) MULTIPLE CONSTRUCTION BUILDING | | | (X3) DATE SURVEY COMPLETED | |
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| | | 345113 | B. WING _ | | | 04/2 | 26/2018 | |
| NAME OF P | ROVIDER OR SUPPLIER | | <u> </u> | STREET ADDRESS, CITY, STAT | E, ZIP CODE | 1 04/2 | 20,2010 | |
| \A/II O\A/ | CDEEK MUDGING AND I | DELIA DII ITATIONI CENTER | 2401 WAYNE MEMORIAL DRIVE | | VE | | | |
| WILLOW | CREEK NUKSING AND | REHABILITATION CENTER | | GOLDSBORO, NC 27534 | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFI) TAG | (EACH CORRECTI CROSS-REFERENC | LAN OF CORRECTION IVE ACTION SHOULD BE ED TO THE APPROPRIA FICIENCY) | | (X5) COMPLETION DATE | |
| F 656 | Resident #1's physic orders to be followed treatments be provid In an interview on 04 stated she expected She indicated she ex treatments to be adm | iew on 04/26/18 at 3:43 PM sian stated he expected his d and all medications and ed. 6/26/18 at 4:15 PM the DON the Care Plan to be followed. Expected all medications and hinistered and that care be ents as directed by the Care | F | unable to be obtained resident medical reconotification QI Audit Tourses and the RN stimmediately notify the identified areas of coin the clinical record awith the license nurse review and initial the QI Audit Tool weekly monthly x 1 month for ensure all areas of coaddressed and docur electronic medical reprovided with the resmember. The Executive QI commonthly and review the notification QI Audit Tourent as needed, to include of monitoring x 3 more part B 100% audit, was initiall current residents for Administration Recorreviewed and compasummaries and phys written/telephone ord Director of Nursing (Almprovement (QI) nursupervisor for the past to 5/2/2018 to ensure orders, to include Duhave been transcribe resident MAR for admedication in accordance in accorda | ord utilizing a MD/R Fool. The ADON, G upervisor, will e MD/RR for any incern and docume and provide retraine e. The DON will RR/MD notification incern were mented in the cords and retraining ponsible staff mmittee will meet the MD/RR Fool to make chang the continued freque enths. ated on 5/2/2018 of Medical rds (MARs) will be red to the discharg ician ters, by the Assista ADON), the Quality rses and the RN st 30 days 4/2/201 the all medication onebs treatments, and correctly to the ministration of the ance with the | RR QI ent ning n to ng ges ency of ge ant y 18 | | |

| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULT A. BUILDI | TIPLE CONST | (RUCTION | (X3) DATE COMP | SURVEY PLETED |
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| | | | | | | | С |
| | | 345113 | B. WING _ | | | 04/ | 26/2018 |
| NAME OF P | ROVIDER OR SUPPLIER | | | STREET | ADDRESS, CITY, STATE, ZIP CODE | | |
| WILLOW | CREEK NURSING AND F | REHABILITATION CENTER | | 2401 WA | YNE MEMORIAL DRIVE | | |
| WILLOW | DREEK HOROMO AND I | CHABIEHATION GENTER | GOLDSBORO, | | BORO, NC 27534 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFI TAG | < | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | | (X5) COMPLETION DATE |
| F 656 | Continued From page | e 11 | F | immonum Nurs re-tropy 6 A 10 nurs inclusting the correction of th | ntified during the audit will be nediately addressed by the Director sing (DON) to include additional raining of staff and will be complete 6/2/2018. Do% in-servicing with all licensed ses, to include nurse #1 and #2, to ude agency nurses, was initiated by Staff Facilitator on 5/2/2018 regard rectly transcribing all physician order nclude following orders from the charge summary, to the MAR to ensemedications are transcribed, to include notes, and administered correctly in ordance with the resident care plant will be completed by 5/4/2018. Gof residents MARs will be review the ADON, the QI nurse and the RN ervisor, to compare to all physician ers, to include the discharge summaners, to include the discharge summaners, to include the resident R for administration of the medicatic coordance with the resident care plocur weekly for 8 weeks, then on the formal content of the medication orders, and the resident care plocur weekly for 8 weeks, then on the formal content of the medication orders and the monthly for 1 month, utilizing a Medican enscription Audit tool. The Director of the sing (DON) will review and initial the dication Transcription Audit tool weeks and then monthly for one on the formal concern were addressed. | y ing ers, sure ude n ved I ary ton an tion of e ekly | |

| | DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ′ | IPLE CONSTRUCTION IG | | (X3) DATE SURVEY COMPLETED |
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| | ROVIDER OR SUPPLIER CREEK NURSING AND R | EHABILITATION CENTER | | STREET ADDRESS, CITY, STATE, ZIP 2401 WAYNE MEMORIAL DRIVE GOLDSBORO, NC 27534 | CODE | 0-4/20/2010 |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN | CTION SHOULD BE THE APPROPRIA | DATE. |
| F 656 F 677 SS=D | ADL Care Provided for CFR(s): 483.24(a)(2) | e 12 or Dependent Residents | F 6 | the MD/RR notification QI Executive Quality Improve committee monthly for 3 r issues, concerns, and/or will be addressed by imple changes as necessary, to continued frequency of materials. The Administrator and the responsible for the impler corrective actions to incluandits, in services, and materials to the plan of correction. | ement (QI) months. Any trends identified ementing of include nonitoring. DON will be mentation of ide all 100% | ed |
| | out activities of daily services to maintain of personal and oral hyg. This REQUIREMENT by: Based on observation interviews the facility a resident's body after (Resident #2). Finding The quarterly Minimu 04/06/18 revealed Restricted anoxic brain and seizure disorder. long term memory proimpaired in daily decimal was totally dependent. | n, record review and staff failed to rinse the soap from roathing for 1 of 1 residents | | F677 ADL Care Provided for Do Residents CFR(s): 483.24(a)(2) The process that lead to the was based on observation and staff interviews the farinse the soap from a resident bathing for 1 of 1 resident pathing for 1 of 1 resident pathing assistants (N #3, by the Assistant Direct (ADON), the Quality Impression of the provident pathing assistants (N #3, by the Assistant Direct (ADON), the Quality Impression of the provident pathing assistants (N #3, by the Assistant Direct (ADON), the Quality Impression of the provident pathing assistants (N #3, by the Assistant Direct (ADON), the Quality Impression of the provident pathing assistants (N #3, by the Assistant Direct (ADON), the Quality Impression of the provident pathing assistants (N #3, by the Assistant Direct (ADON), the Quality Impression pathing assistants (N #3, by the Assistant Direct (ADON), the Quality Impression pathing assistants (N #4). | the deficiency n, record revie acility failed to ident⊡s body sidents (reside censed nurses IA), to include | ew ent s NA |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
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| NAME OF B | 201/1252 02 01/221/152 | 345113 | B. WING _ | | | 1/26/2018 | |
| NAME OF PI | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODI | E | | |
| WILLOW (| CREEK NURSING AND I | REHABILITATION CENTER | | 2401 WAYNE MEMORIAL DRIVE | | | |
| | | | | GOLDSBORO, NC 27534 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | SHOULD BE | (X5) COMPLETION DATE | |
| F 677 | Continued From pag | e 13 | F 6 | 77 | | | |
| F 677 | bathing related to hy quadriplegia. The go was for Resident #2 free. Interventions in make sure hair was manicured on Wedner In an observation of AM Nursing Assistant for Resident #2. A b brought to the bedsic in the water and NA face. Body wash wa and the cloth was pla Multiple soapy wash Resident #2's body a was used to rinse he clear water to rinse the body during the bath Immediately following the shampoo and bo Resident #2's bath we revealed: "Moisten so Apply gel, lather and In an interview on 04 stated it was her first | poxic brain injury and bal through the next review to be neat, clean and odor included bed baths, and to washed and nails were esdays. bathing on 04/26/18 at 11:05 at (NA) #3 provided privacy asin of warm water was die. A washcloth was dipped #3 washed Resident #2's applied to the washcloth aced into the basin of water. Cloths were used to wash and the same soapy water or body. NA #3 did not use the soap from Resident #2's at the bath the directions on dy wash provided for as reviewed. The directions calp, skin, or washcloth. | F 6 | nurses, the RN supervisor and Facilitator on giving a bath to to include resident #2, to ensuprocedure is being followed to rinsing off soap if a no rinse sused during the bath and will completed by 5/2/2014 utilizin Care audit tool for bath observed. An inservice for 100% of all lic nurses and NA s, to include initiated by the Staff Facilitato 5/3/2014 regarding the correct for giving a resident a bath to rinsing off the soap unless and is used and will be completed 5/4/2018. 10% of all licensed nurses and include NA #3, will be observed bath to a resident, to include rinsing that the correct proced giving a bath, to include rinsin soap, is being followed, week weeks and then monthly for outilizing a Resident Care audit bath observations. The Direct | a resident, ure correct o include oap is not be g a Resident vation. censed NA #3 was r on t procedure include to rinse soap by d NA s, to ed giving a resident #2, RN ucilitator to dure for g off the ly for 8 ne month t tool for | | |
| | wash she stated she from Resident #2's b | had not rinsed the soap ody. She indicated it was se the soap off the body | | Nursing (DON) will review and Resident Care audit tool for be observations weekly for 8 week monthly for one month to ensure of concern were addressed. | ath eks and then | | |
| | indicated it was her | /26/18 at 4:15 PM the DON expectation that aides rinse ents they were bathing unless no rinse soap. | | The administrator will review a the findings of the Resident C tool to the Executive QI comm monthly for 3 months. Any iss | are audit nittee | | |

| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ' ' | (2) MULTIPLE CONSTRUCTION BUILDING | | | (X3) DATE SURVEY COMPLETED | |
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| | ROVIDER OR SUPPLIER | EHABILITATION CENTER | | 24 | TREET ADDRESS, CITY, STATE, ZIP CODE 401 WAYNE MEMORIAL DRIVE OLDSBORO, NC 27534 | 1 047 | 20/2010 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFI TAG | x | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | | (X5) COMPLETION DATE | |
| F 690 SS=D | Continued From page Bowel/Bladder Incont CFR(s): 483.25(e)(1) | inence, Catheter, UTI | | 690 | concerns, and/or trends identified will be addressed by implementing changes a necessary, to include continued freque of monitoring. The Administrator and the DON will be responsible for the implementation of corrective actions to include all 100% audits, in services, and monitoring relato the plan of correction. | s ncy ted | 5/14/18 | |
| | resident who is continuadmission receives simaintain continence is condition is or become not possible to maintain \$483.25(e)(2)For a reincontinence, based comprehensive assessent that— (i) A resident who entindwelling catheter is resident's clinical concatheterization was not wii) A resident who entindwelling catheter or is assessed for removas possible unless the demonstrates that caland (iii) A resident who is receives appropriate | cility must ensure that nent of bladder and bowel on ervices and assistance to unless his or her clinical es such that continence is ain. esident with urinary on the resident's esment, the facility must ers the facility without an not catheterized unless the dition demonstrates that | | | | | | |

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| TICH (| and Plan of | OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | l ` ′ | PLE CONSTRUCTION G | ` ′сомі | E SURVEY PLETED |
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| NAME OF PROVIDER OR SUPPLIER WILLOW CREEK NURSING AND REHABILITATION CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE | | | 345113 | B. WING | | | |
| PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE | | | | | 2401 WAYNE MEMORIAL DRIVE | 04 | 72072010 |
| TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | | (EACH DEFICIENC | CY MUST BE PRECEDED BY FULL | | (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO | LD BE | (X5) COMPLETION DATE |
| F 690 Continued From page 15 continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on record review and staff and physician interviews the facility failed to obtain a urine sample for urinalysis and culture and sensitivity as ordered by the physician for 1 of 1 residents (Resident #1) who experienced burning on urination. Findings included: Review of the admission Minimum Data Set (MDS) dated 10/12/17 revealed Resident #1 was cognitively intact. Resident #1 had diagnoses of heart failure, Chronic Obstructive Pulmonary Disease (COPD), and atrial fibrillation. Review of Resident #1's Care Plan created 10/18/17 revealed interventions of: observe for signs and symptoms of Urinary Tract Infection (UT1) and notify physician for possible intervention, obtain labs as ordered and notify physician of abnormal findings. Resident #1 was re-admitted to the facility from the hospital on 11/27/17 with diagnoses UTI and an acute exacerbation of COPD. Review of the Skilled/Post-Acute nursing note dated 12/03/17 at 9-47 AM revealed that Resident #1 had complained of a burning sensation on when the labs are unable to be obtained, when the labs are unable to be obtained, when the labs are unable to be obtained. | F 690 | continence to the ext §483.25(e)(3) For a r incontinence, based comprehensive asse ensure that a resider receives appropriate restore as much norr possible. This REQUIREMENT by: Based on record rev interviews the facility sample for urinalysis as ordered by the ph (Resident #1) who ex urination. Findings in Review of the admiss (MDS) dated 10/12/1 cognitively intact. Re heart failure, Chronic Disease (COPD), and Review of Resident #1 10/18/17 revealed int signs and symptoms (UTI) and notify phys intervention, obtain la physician of abnorma Resident #1 was re-a the hospital on 11/27 an acute exacerbatio Review of the Skilled dated 12/03/17 at 9:4 | resident with fecal on the resident's ssment, the facility must at who is incontinent of bowel treatment and services to mal bowel function as It is not met as evidenced riew and staff and physician failed to obtain a urine and culture and sensitivity sysician for 1 of 1 residents experienced burning on included: Is sion Minimum Data Set revealed Resident #1 was resident #1 had diagnoses of redobstructive Pulmonary diatrial fibrillation. It is Care Plan created terventions of: observe for of Urinary Tract Infection ician for possible reds as ordered and notify all findings. Indimitted to the facility from redomitted to the fac | F 6 | F690 Bowel/Bladder Incontinence, Cather UTI CFR(s): 483.25(e)(1)-(3) The process that lead to the deficie was based on record review and staphysician interviews the facility failer obtain a urine sample for urinalysis culture and sensitivity as ordered by physician for 1 of 1 residents (resid who experienced burning on urination A 100% review of all residents proportion of Nursing (ADON), the Quality of Nursing (ADON), the Quality of Nursing (ADON) in the Nursing (ADON) in the Quality of | ncy aff and ed to and y the ent #1) on. ogress stant uality N 2018, on, to and een en labs and | |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 ' ' | IPLE CONSTRUCTION NG | | (X3) DATE SURVEY COMPLETED | |
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| | | 345113 | B. WING_ | | | /26/2018 | |
| NAME OF PI | ROVIDER OR SUPPLIER | l | | STREET ADDRESS, CITY, STATE, ZIP CO | | | |
| | | | | 2401 WAYNE MEMORIAL DRIVE | | | |
| WILLOW | CREEK NURSING A | ID REHABILITATION CENTER | | GOLDSBORO, NC 27534 | | | |
| (X4) ID | SUMMAR | Y STATEMENT OF DEFICIENCIES | ID | PROVIDER'S PLAN OF CO | ORRECTION | (X5) | |
| PRÉFIX TAG | , | ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION) | PREFI) TAG | ((EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY | E APPROPRIATE | COMPLETION DATE | |
| F 690 | Continued From p | page 16 | F 6 | 690 | | | |
| | aware. | | | 05/03/2018. The resident□s | physician | | |
| | | | | and/or RR will be notified of | | | |
| | Review of the Phy | ysician Orders dated 12/03/17 | | areas of concern and the not | tification will | | |
| | revealed an order | to obtain a urine sample for a | | be documented in the reside | nt□s medical | | |
| | urinalysis (UA) ar | d culture and sensitivity (C&S). | | record by the Assistant Direc | ctor of Nursing | | |
| | | facility order for UA and C&S in | | (ADON), the Quality Improve | | | |
| | December 2017. | | | nurses and/or RN supervisor | | | |
| | | | | completed by 06/03/2018 uti | lizing a | | |
| | Review of the me | | | resident census. | | | |
| | | 7 revealed no results for the | | An incoming was initiated for | . 1000/ of all | | |
| | ordered UA and C | <i>,</i> &5. | | An inservice was initiated for licensed nurses, to include n | | | |
| | Deview of the He | alth Status nursing note dated | | #3 and #5, to include agency | | | |
| | | PM revealed Nurse #1 had | | 05/03/2018 by the Staff Faci | | | |
| | | in a urine sample but had been | | regarding notification of phys | | | |
| | | e note indicated that Nurse #1 | | RR of any significant change | | | |
| | would make the o | ncoming nurse aware of | | resident □s condition to inclu | | | |
| | Resident #1's bur | | | are ordered, to include urine | for | | |
| | | | | complaints of burning on urir | nation, and | | |
| | Review of the Ski | lled/Post-Acute nursing note | | the labs are unable to be obt | tained and | | |
| | | 10:54 AM revealed an order | | that documentation of notific | | | |
| | had been given fo | or a UA with C&S. | | entered into the resident□s r | | | |
| | | | | record, will be completed by | 05/04/2018. | | |
| | | lled/Post-Acute nursing note | | \\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\ | | | |
| | | 7:58 PM revealed Resident #1 | | When there is any significant | | | |
| | _ | ination and an order had been | | resident⊡s condition, to inclu | | | |
| | given for a UA wit | II Cas. | | are ordered, to include urine complaints of burning on urir | | | |
| | Review of the Ski | lled/Post-Acute nursing note | | the labs are unable to be obt | | | |
| | | 3:17 AM revealed the nurse | | license nurse is responsible | | | |
| | | ve the UA and C&S done. | | the resident physician and/or | | | |
| | | | | documenting in the residents | | | |
| | In an interview on | 04/24/18 at 3:38 PM Nurse #1 | | medical records. The ADON | | | |
| | | Resident #1 on 12/03/17 stated | | and the RN supervisor will re | • | | |
| | if a resident comp | lained of burning on urination | | residents progress notes, da | ily 3 times a | | |
| | | notify the physician and get an | | week for 4 weeks then week | • | | |
| | | h C&S. She indicated when the | | then monthly x 1 month to er | | | |
| | | to the facility the physician | | appropriate documentation for | | | |
| | should be notified | of the result. Nurse #1 stated | | of the physician and/or RR, f | or any | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
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| | | 345113 | B. WING_ | | | | C |
| NAME OF D | DOVIDED OD CLIDDLIED | 343113 | B: Wii(0 = | | TREET ARRESCO CITY STATE ZIR CORE | 04 | /26/2018 |
| NAME OF PI | ROVIDER OR SUPPLIER | | | | TREET ADDRESS, CITY, STATE, ZIP CODE | | |
| WILLOW | CREEK NURSING AND R | REHABILITATION CENTER | | | 101 WAYNE MEMORIAL DRIVE | | |
| | | | | G | OLDSBORO, NC 27534 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | × | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | | (X5) COMPLETION DATE |
| F 690 | Continued From page | e 17 | F 6 | 590 | | | |
| | she had attempted to | collect urine from Resident | | | changes in the resident, to include who | en | |
| | • | successful. She indicated | | | labs are ordered, to include urine for | | |
| | | oming nurse that the urine | | | complaints of burning on urination, an | d | |
| | | She stated she did not | | | the labs are unable to be obtained, is | | |
| | | re the urine sample had | | | recorded in the resident medical record | t | |
| | been collected and se | · · · · · · · · · · · · · · · · · · · | | | utilizing a MD/RR notification QI Audit | | |
| | | · | | | Tool. The ADON, QI nurses and the RI | 1 | |
| | In an interview on 04 | /25/18 at 1:55 PM the | | | supervisor, will immediately notify the | | |
| | Director of Nursing (D | OON) verified that no urine | | | MD/RR for any identified areas of cond | ern | |
| | sample had been sent to the laboratory for analysis as requested by the physician on | | | | and document in the clinical record and | t | |
| | | | | | provide retraining with the license nurs | | |
| | 12/03/17. | | | | The DON will review and initial the RR | | |
| | | | | | notification QI Audit Tool weekly x 8 we | | |
| | | /25/18 at 3:05 PM Nurse #3 | | | then monthly x 1 month for completion | | |
| | | ent #1 on 12/09/17 stated | | | and to ensure all areas of concern wer | е | |
| | | r getting an order for a | | | addressed and documented in the | | |
| | _ | g a urine sample from | | | electronic medical records and retraini | ng | |
| | | viewing her note from | | | provided with the responsible staff | | |
| | | ed she must have received | | | member. | | |
| | the physician or obtai | ort but that she did not call | | | The Executive QI committee will meet | | |
| | line priysician or obtai | in the unite sample. | | | monthly and review the MD/RR | | |
| | In an interview on 04 | /25/18 at 5:09 PM Nurse #2 | | | notification QI Audit Tool to make chan | 200 | |
| | | ting Nurse #1 with charting | | | as needed, to include continued freque | _ | |
| | | licated Resident #1 told her | | | of monitoring x 3 months. | | |
| | | nt that she had been having | | | 2cg x o monato. | | |
| | _ | Nurse #2 informed Nurse | | | The Administrator and the DON will be | | |
| | _ | her she would call the | | | responsible for the implementation of | | |
| | | an order for the urine test. | | | corrective actions to include all 100% | | |
| | | did not call the physician to | | | audits, in services, and monitoring rela | ted | |
| | | nt #1's symptoms or that the | | | to the plan of correction. | | |
| | | boratory tests had not been | | | · | | |
| | I - | ated someone should have | | | | | |
| | followed up on the mi | | | | | | |
| | · · | ew on 04/26/18 at 3:43 PM | | | | | |
| | | an stated he expected his | | | | | |
| | orders to be followed | . He indicated the facility | | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIF IDENTIFICATION NUMBER: A. BUILDING | | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | | 345113 | B. WING | | C 04/26/2018 |
| | ROVIDER OR SUPPLIER CREEK NURSING AND I | REHABILITATION CENTER | : | STREET ADDRESS, CITY, STATE, ZIP CODE 2401 WAYNE MEMORIAL DRIVE GOLDSBORO, NC 27534 | 1 0 1120120 10 |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG PROVIDER'S PLAN OF CORRECTI PREFIX (EACH CORRECTIVE ACTION SHOUL TAG CROSS-REFERENCED TO THE APPRO DEFICIENCY) | | BE COMPLÉTION | | |
| F 695 SS=D | results of the laborate indicated he did not be expected to be notified not be completed so explored. In a follow-up interviet the DON stated it was for laboratory tests be She indicated some conthe missing UA are Respiratory/Tracheos CFR(s): 483.25(i) § 483.25(i) Respirate tracheostomy care and tracheostomy care and tracheal succare, consistent with practice, the comprescare plan, the reside and 483.65 of this sufficient interviews respiratory medication. | out notifying him of the ory tests he ordered. He know what happened but he ed if laboratory tests could other options could be ew on 04/26/18 at 4:15 PM sher expectation that orders e completed as ordered. One should have followed-up and C&S. estomy Care and Suctioning ory care, including and tracheal suctioning. Unre that a resident who are, including tracheostomy cotioning, is provided such professional standards of thensive person-centered ants' goals and preferences, | F 695 | | 5/14/18 |
| | whose medications vincluded: Review of the admiss (MDS) dated 10/12/1 cognitively intact. Rediagnoses of heart fa | sion Minimum Data Set 7 revealed Resident #1 was esident #1 had admission fillure, Chronic Obstructive (COPD), and atrial fibrillation. | | The process that lead to the deficience was based on record and staff, family and physician interviews the facility fa to provide respiratory medications as ordered by the physician for 1 of 1 residents (resident #1). Resident #1 relonger resides in the facility. | iled |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ′ | LE CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
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| | | 345113 | B. WING | | C | |
| NAME OF PE | ROVIDER OR SUPPLIER | 0.0 | | STREET ADDRESS, CITY, STATE, ZIP CODE | 04/26/2018 | |
| TVAINE OF T | TO VIDER OR OUT FILE | | | , , , | | |
| WILLOW (| CREEK NURSING AND F | REHABILITATION CENTER | | 2401 WAYNE MEMORIAL DRIVE | | |
| | | | | GOLDSBORO, NC 27534 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | SUMMARY STATEMENT OF DEFICIENCIES ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG (C) | | PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | D BE COMPLETION | |
| F 695 | Continued From page | e 19 | F 69 | 5 | | |
| | the hospital on 11/27 Tract Infection (UTI) of COPD. Review of the hospital 11/27/17 under Presonan order for Ipratropia (milliliters) via a nebula Review of the handwown Medication Administrative revealed no order for Duoneb every 4 hours. | ritten 11/27/17-11/30/17 ation Record (MAR) the administration of s. | | all current residents Medical Administration Records (MARs) will reviewed and compared to the disch summaries and physician written/telephone orders, by the Ass Director of Nursing (ADON), the Qu Improvement (QI) nurses and the R supervisor for the past 30 days. 4/2- to 5/25/2018 to ensure all medicatio orders, to include Duonebs treatmen have been transcribed correctly to the resident MAR. Any areas of concern identified during the audit will be immediately addressed by the Direct Nursing (DON) to include additional | be narge sistant ality N 5/2018 on nts, he n | |
| | dated 11/14/17 with r | generated order for Duoneb no scheduled times for RN (as needed) was written n. | | training of staff and will be complete 6/25/2018. 100% in-servicing with all licensed r to include nurse #1 and #2, to include | nurses, | |
| | nursing notes revealerespirations at times, and that nebulizer tregiven as needed. | aber 2017 Health Status ed Resident #1 had labored was short of breath at times atments and oxygen were | | agency nurses, was initiated by the Staff Facilitator on 5/2/2018 regarding correctly transcribing all physician orders, to include following orders from the discharge summary, to the MAR to ensure all medications are transcribed, to include | | |
| | In a telephone interview on 04/24/18 at 4:57 PM Resident #1's family member stated both she and Resident #1 had told the nurses numerous times that the Resident was supposed to be getting regular nebulizer breathing treatments. In an interview on 04/25/18 at 2:11 PM the Consultant Pharmacist stated when she | | | Duonebs, and administered correctly will be completed by5/4/2018. 10% of residents□ MARs will be reverbed by the ADON, the QI nurse and the supervisor, to compare all physicial orders, to include duoneds and the discharge summary to the resident | riewed RN n | |
| | performed the month residents she looked | ly pharmacy reviews for the at any recent hospital for medications, reviewed | | to ensure all medication orders are transcribed correctly weekly for 8 w then monthly for 1 month, utilizing a | eeks, | |

| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ′ | IPLE CONSTRUCTION | | (X3) DATE SU COMPLE | |
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| | | 345113 | B. WING _ | | | C 04/2 6 | 6/2018 |
| | ROVIDER OR SUPPLIER | REHABILITATION CENTER | | STREET ADDRESS, CITY, STATE, ZII 2401 WAYNE MEMORIAL DRIVE GOLDSBORO, NC 27534 | P CODE | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE | ACTION SHOULD BE O THE APPROPRIA | - | (X5) COMPLETION DATE |
| F 695 | new orders from the she did not review the kept on their carts. The resident was re-admition hospital all previous and the new orders when she reviewed December 2017, the medications listed Dours. She stated we Physician Order she that the Duoneb was hours and that there orders written for the linear interview on 04 indicated Resident #1 was suppreathing treatments checked the orders of clarification. In an interview on 04 stated she had transed Discharge orders to indicated another number to the linear to the Duoneb of MAR. In a telephone interview on 04 stated she had transed been done since signatures. She indinext to the Duoneb of MAR. In a telephone interview re-admitted to the expected the hospital she had the she indinext to the physical she indinext to the Duoneb of MAR. | sheets, and looked for any physician. She indicated he paper MAR that the nurses she indicated when a litted to the facility from the orders were discontinued were put in place. She stated Resident #1's record in hospital discharge uoneb to be given every 4 when she looked at the lets for December she saw is listed to be given every 4 had been no change in | F | Medication Transcription Director of Nursing (DON initial the Medication Tra tool weekly for 8 weeks a for one month for comple ensure all areas of conce addressed. The administrator and/or review and present the fi Medication Transcription Executive Quality Improv committee monthly for 3 issues, concerns, and/or will be addressed by imp changes as necessary, to continued frequency of n The Administrator and th responsible for the imple corrective actions to inclus audits, in services, and n to the plan of correction. | N) will review an nscription Audi and then month etion and to ern were The DON will indings of the Audit tool to the ement (QI) months. Any trends identified blementing to include monitoring. The DON will be ementation of ude all 100% monitoring relations. | nd t nlly | |

| | OF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | PLE CONSTRUCTION G | ' ' | OMPLETED |
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| | | 345113 | B. WING | | | C 04/26/2018 |
| | ROVIDER OR SUPPLIER CREEK NURSING AND F | REHABILITATION CENTER | | STREET ADDRESS, CITY, STATE, ZIP CODE 2401 WAYNE MEMORIAL DRIVE GOLDSBORO, NC 27534 | | 04/25/2510 |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY) | OULD BE | (X5) COMPLETION DATE |
| F 695 F 725 SS=D | bronchodilator (used passages) and that Freceived scheduled it was what was ordered any questions the fact about calling him to a linear any questions the fact about calling him to a linear any questions to be transpital discharge sure to be administered at there were questions call the physician to Sufficient Nursing States (CFR(s): 483.35(a)(1) §483.35(a) Sufficient The facility must have the appropriate comprovide nursing and practicable physical, well-being of each reresident assessment and considering the diagnoses of the faci accordance with the at §483.70(e). §483.35(a)(1) The faci by sufficient numbers types of personnel or nursing care to all reresident care plans: (i) Except when waive this section, licensed | to open the breathing Resident #1 should have breathing treatments if that ed. He indicated if there were cility was usually pretty good ask for clarification. /26/18 at 4:15 PM the DON) stated she expected inscribed correctly from the immary and for medications is ordered. She indicated if it is she expected the nurse to clarify the orders. aff (2) Staff. The sufficient nursing staff with breather in the state of the services to assure attain or maintain the highest mental, and psychosocial sident, as determined by and individual plans of care number, acuity and lity's resident population in facility assessment required cility must provide services is of each of the following in a 24-hour basis to provide sidents in accordance with | F 6 | | | 5/14/18 |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | I DENTIFICATION NUMBER: | | MULTIPLE CONSTRUCTION JILDING | | (X3) DATE SURVEY COMPLETED | |
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| | | 345113 | B. WING | | | C 04/26/2018 | |
| NAME OF PI | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE | 1 ' | J4/26/2016 | |
| | | | | 2401 WAYNE MEMORIAL DRIVE | | | |
| WILLOW | CREEK NURSING AND F | REHABILITATION CENTER | | GOLDSBORO, NC 27534 | | | |
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| F 725 | Continued From page | | F 72 | 25 | | | |
| | limited to nurse aides | imited to nurse aides. | | | | | |
| | designate a licensed nurse on each tour of This REQUIREMENT by: Based on record rev facility failed to ensur Nursing Assistants (Norespond to each residents (Resident # The quarterly Minimus 04/06/18 revealed Rest the facility on 09/25/11 included anoxic brain and seizure disorder. Iong term memory profit in daily decives to tally dependent Review of the Daily Shad been assigned to halls on day shift 04/15 to have left early. The orienting to the unit the Review of the Daily A 04/18/18 revealed Nawas assigned to care 501-503A and 701-70 care for the residents | section, the facility must nurse to serve as a charge of duty. T is not met as evidenced of iew and staff interviews the real sufficient number of staff in the | | F725 CFR (s): 483.35 (a) (1) (2) The process that lead to the define was based on record review and interviews the facility failed to ensufficient number of Nursing Ass (NAs) to provide care and responseach residents needs for 1 of 1 received (resident #2). On 05/14/2018, the Director of New (DON) and the Administrator revictinical staffing schedule to ensusufficient staff were on duty to make a care needs of the residents, to pushowers/baths, per resident prefit to include for Resident #2. The Director of New the daily clinical staffing in hours prior to the scheduled work ensure that clinical staff are on direct the needs of the residents. Weekly case mix index will be reviewely to ensure the acuity of the residents is taken into account we clinical staffing patterns to meet to the residents, including the new Resident #2. | staff sure a istants and to esident lursing iewed the re that eet the roviding erences, DON will leeds 24 ktimes to uty to The viewed e ith the the needs | | |
| | | e Daily Assignment sheet ignment for the aide that left | | On 05/14/2018, the Facility Nurs Consultant in-serviced the Admir and the DON in regards to Suffice | nistrator | | |

PRINTED: 06/04/2018 FORM APPROVED OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | I ` ′ | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
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| | | | | | | | С | |
| | | 345113 | B. WING | | | 04 | /26/2018 | |
| NAME OF P | ROVIDER OR SUPPLIER | | | S1 | TREET ADDRESS, CITY, STATE, ZIP CODE | | | |
| WILLOW | CDEEK NIIDGING AN | ID DELIABII ITATION CENTED | | 24 | 401 WAYNE MEMORIAL DRIVE | | | |
| WILLOW | CREEN NURSING A | ID REHABILITATION CENTER | | G | OLDSBORO, NC 27534 | | | |
| (X4) ID PREFIX | (EACH DEFIC | Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION) | BE PRECEDED BY FULL PREFIX (EACH COR | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR | CTION SHOULD BE COMPLET | | |
| TAG | REGULATORT | ON LOG IDENTIF TING INFORMATION) | TAG | | DEFICIENCY) | IAIL | | |
| E 705 | | | | | | | | |
| F 725 | Continued From p | <u>-</u> | F | 725 | | | | |
| | | h Type record dated 04/18/18 | | | to include: | | | |
| | | mentation that a bath was given | | | | | | |
| | to Resident #2 that | at day. | | | The facility must provide services | | | |
| | | | | | sufficient numbers of each of the follo | wing | | |
| | | 04/25/18 at 9:40 AM Nurse #4 | | | types of personnel on a 24 hour basis | to | | |
| | stated she had no | t been told by any aides on | | | provide nursing care to all residents ir | 1 | | |
| | 04/18/18 that they | | | accordance with resident care plan. | | | | |
| | the residents bec | | | | | | | |
| | staff. | | | | 2. The determination of sufficient sta | aff | | |
| | | | | | will be made based on the staff □s ab | lity | | |
| | In a telephone interview on 04/25/18 at 1:05 PM | | | | to provide needed care to residents the | ıat | | |
| | NA #4 stated she | had been the only aide who | | | enable them to reach their highest | | | |
| | worked on the 70 | 0 hall on day shift on 04/18/18. | | | practicable physical, mental, and | | | |
| | She indicated the | She indicated there was an orientee who worked | | | psychosocial well-being. | | | |
| | on the hall but no | t another aide. She indicated | | | The facility has hired additional licens | ed | | |
| | she had not been | able to provide a bath to | | | nurses and nursing assistants to fill th | e | | |
| | | use she had been too busy | | | vacant position in the current schedul | | | |
| | | other residents and answering | | | The facility will utilize agency staffing | | | |
| | call lights. | ū | | | ensure daily staffing is sufficient accordance | | | |
| | | | | | to the acuity level of the residents and | | | |
| | In an interview on | 04/25/18 at 4:55 PM the | | | ensure the needs of residents are me | | | |
| | Scheduler stated | there were four aides and an | | | including for Resident #1. | | | |
| | orientee schedule | ed to work the day shift on | | | · · | | | |
| | | 00 and 700 halls. She indicated | | | The scheduling coordinator will be no | tified | | |
| | NA #6 had to leav | re early due to an emergency | | | of night and weekend call-ins and no | | | |
| | | es and the orientee to cover the | | | shows promptly. The scheduling | | | |
| | _ | . The Scheduler stated she | | | coordinator will make necessary | | | |
| | sent the Restorat | ve NAs (RNA) to assist with the | | | arrangements to ensure adequate sta | ff | | |
| | | indicated that after review of | | | are on duty. If the scheduling coordinate | | | |
| | _ | n for 04/18/18 RNA #1 had | | | is unable to obtain adequate staff or if | | | |
| | bathed Resident | | | | outside of the scheduling coordinators | | | |
| | | | | | normal working hours, the ADON or the | | | |
| | In an interview on | 04/26/18 at 12:00 PM RNA #1 | | | DON will be notified promptly. The fac | | | |
| | | bathe Resident #2 on 04/18/18 | | | administrator and DON will provide | • | | |
| | | not been pulled to work on the | | | ongoing monitoring daily to ensure the | at | | |
| | 700 hall as an aid | • | | | there is adequate clinical staff on duty | | | |
| | | | | | provide needed care to residents that | | | |
| | In an interview on | 04/26/18 at 12:10 PM RNA #2 | | | enable them to reach their highest | | | |
| | | give a bath to Resident #2 on | | | practical physical, mental and | | | |

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| AND PLAN OF CORRECTION IDENTIFICATIO | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ′ | LE CONSTRUCTION | | (X3) DATE SURVEY COMPLETED | |
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| | | 345113 | B. WING | | C 04/26/2018 | | |
| NAME OF PROVIDER OR SUPPLIER | | | -1 - | STREET ADDRESS, CITY, STATE, ZIP CODE | 1 04 | 720/2010 | |
| | NAME OF PROVIDER OR SUPPLIER | | | 2401 WAYNE MEMORIAL DRIVE | | | |
| WILLOW | CREEK NURSING AND F | REHABILITATION CENTER | | GOLDSBORO, NC 27534 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY) | OULD BE | (X5) COMPLETION DATE | |
| F 725 | Continued From page | e 24 | F 72 | 5 | | | |
| | 04/18/18 and had no | | | psychosocial wellbeing. | | | |
| | indicated she did not | /26/18 at 12:12 PM RNA #3 bathe Resident #2 on t given a hall assignment. | | On 05/14/2018, all licensed nurse nursing assistants were in-servic the scheduling coordinator is the of contact for any and all scheduling coordinates. | ed that first point ling | | |
| | In an interview on 04/26/18 at 1:50 PM Nurse #6 indicated the hall nurses were responsible for making sure the Daily Assignment sheet was updated to reflect the correct assignments and distribution of care. In an interview on 04/26/18 at 1:55 PM NA #6 indicated she left the facility at about 8:30 AM on 04/18/18. She indicated she had informed the nurse that she had not completed her assigned baths for that day. She indicated she had never | | | issues that arise while on shift and procedure for notifying the ADON or DON after hours and on weekends for further scheduling issues. The ADON & DON's contact information will be posted in designated employee areas and will | | | |
| | | | | include subsequent points of con which will be available 24/7 to av single point of failure. All newly hired licensed nurses a nursing assistants will be in-serving assistants. | oid a nd iced | | |
| | Orientee stated that orientation. She indi | nly aide on the hall. /26/18 at 2:40 PM the NA 04/18/18 was her first day of cated she and NA #4 were orked day shift on the 700 | | during orientation by the Staff Fa that the scheduling coordinator is point of contact for any and all so issues that arise while on shift ar procedure for notifying the ADON after hours and on weekends for scheduling issues. Copy of containformation for schedule related in | s the first cheduling nd I or DON further ict | | |
| | In an interview on 04/26/18 at 2:42 PM NA #1 verified that the Daily Assignment sheet was incorrect and that she did not work on the 700 hall on day shift on 04/18/18. She indicated she was concerned that the NA Orientee was going to quit that day due to the 700 hall being short staffed. In a follow-up interview on 04/26/18 at 4:25 PM the Scheduler stated that Mondays, Wednesdays, and Fridays were the most common days for call-outs. If there were call-outs staff was moved around to cover assignments, staff was asked to | | | will be posted in designated area The Administrator and/ or the DC audit staffing schedule at the beg each shift to include nights and w x 4 weeks then twice weekly x 4 then monthly x 1 month utilizing t Sufficient Staff Audit Tool to ensu sufficient staff to meet the needs residents based upon the acuity identified by the Case Mix index assuring the residents reach thei practicable physical, mental and | on will ginning of weekends weeks the level as score | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
|--|--|--|---|---|--|----------------------------|----------------------------|
| 345113 | | B. WING | | | C 04/26/2018 | | |
| NAME OF PROVIDER OR SUPPLIER WILLOW CREEK NURSING AND REHABILITATION CENTER | | | | 24 | TREET ADDRESS, CITY, STATE, ZIP CODE 801 WAYNE MEMORIAL DRIVE OLDSBORO, NC 27534 | 1 0-11 | 20/2010 |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | ID PREFIX TAG | | | | (X5) COMPLETION DATE |
| F 725 | Scheduler stated the which required staff to each month on assign indicated there were to worked the 500 and 7 each shift for day and aides on night shift. Sout the Daily Assignment to verify who actually 04/18/18. She stated the hall nurses to do on the Daily Assignment on the Daily Assignment on the Daily Assignment on the Daily Assignment of Staff assignments to be system for call-outs a cared for. | s called in to work. The facility used a "dot" system of work extra hours twice need days if needed. She usually four aides who would would be a signments on a evening shifts and three worked on the | F7 | psychosocial well-being. All areas of concern will be immediately address the DON/Administrator to include us administrative nurses pulled to the homeet resident care needs. The Administrator will initial the Sufficients are appropriate to meet the needs of the resident care identified their acuity level from the Case Mix Report. The Administrator will forward the resident Staff Audit Tool to the Executive QI Committee monthly x 3 months. The Executive QI Committee meet monthly x 3 months and review Sufficient Staff Audit Tool to determine trends and / or issues that may need further attention. The Administrator and the DON will responsible for the implementation of corrective actions to include all 1009 audits, in services, and monitoring reto the plan of correction. | | of to ent lex will ne | 5/14/18 |
| SS=D | CFR(s): 483.45(f)(2) The facility must ensu §483.45(f)(2) Resider medication errors. This REQUIREMENT by: Based on record reviinterviews the facility | - | | | F760 Residents are Free of Significant Med Errors | | J. 14/ 10 |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | IDENTIFICATION NUMBER: A. BUIL | | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | | | (X3) DATE SURVEY COMPLETED C 04/26/2018 | |
|---|---|---|-----|--|---|--|--|--|
| | | | | | | | | |
| WINE OF TROVIDER OR OUT ELER | | | | | 401 WAYNE MEMORIAL DRIVE | | | |
| WILLOW | CREEK NURSING AND R | EHABILITATION CENTER | | GOLDSBORO, NC 27534 | | | | |
| (X4) ID PREFIX TAG | | | | | | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE | | |
| F 760 | Continued From page | e 26 | F 7 | 760 | | | | |
| | | ted in a significant of 1 residents (Resident ns were reviewed. Findings | | | CFR(s): 483.45(f) (2) | | | |
| | included: | | | The process that lead to the deficiency was based on record review and staff a | | | | |
| | Review of the admiss (MDS) dated 10/12/1 cognitively intact. Re | | | physician interviews the facility failed to provide 138 doses of an ordered scheduled respiratory medication |) | | | |
| | diagnoses of heart fa Pulmonary Disease (| | | (Duoneb) which resulted in a significan medication error for 1 of 1 residents (resident #1) whose medications were | t | | | |
| | | dmitted to the facility from /17 with diagnoses of Urinary | | | reviewed. | | | |
| | | and an acute exacerbation | | | 100% audit, was initiated on 5/2/2018 of all current residents Medical Administration Records (MARs) will be | | | |
| | 11/27/17 under Preso | al Discharge Summary dated driptions: Continue, revealed dum/Albuterol (Duoneb) 3 ml dizer every 4 hours. | | | reviewed and compared to the discharge summaries and physician written/telephone orders, by the Assistance Director of Nursing (ADON), the Quality | ge ant | | |
| | Order sheets, where medications were har | 17-11/30/17 Physician's the hospital discharge nd written, revealed no entry Physician Orders had not | | | Improvement (QI) nurses and the RN supervisor for the past 30 days, 4/3/20 to 5/3/2018 to ensure all medication orders, to include Duonebs treatments have been transcribed correctly to the | | | |
| | been signed off by ar | | | | resident MAR. Any areas of concern identified during the audit will be | | | |
| | Administration Recor | 17-11/30/17 Medication d (MAR) revealed no entries of Duoneb every 4 hours. | | | immediately addressed by the Director Nursing (DON) to include additional training of staff and will be completed by 5/4/2018. | | | |
| | sheets revealed a coldated 11/14/17 for Duhours using a nebuliz | 17-12/31/17 Physician Order mputer generated order noneb to be given every 4 er. There were no dministration of the Duoneb. | | | On 5/2/2018, a 100% medication pass audit with all licensed nurses, to includ nurse #1 and #2, to include agency nurses, and medication aides on prope medication administration to include fiv | e er | | |
| | | 1's 12/01/17-12/31/17 MAR es of Nurse #1 and Nurse | | | rights was initiated by the Staff Facilitato ensure proper medication | | | |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | IDENTIFICATION NUMBER: | | 2) MULTIPLE CONSTRUCTION BUILDING | |
|---|--|--|------------------------|--|--|---------------------|
| | | | | | | С |
| | | 345113 | B. WING _ | | - | 04/26/2018 |
| NAME OF P | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STA | ATE, ZIP CODE | |
| WILLOW | CDEEK MIIDSING AN | D REHABILITATION CENTER | | 2401 WAYNE MEMORIAL DR | RIVE | |
| WILLOW | CREEK NORSING AN | D REHABILITATION CENTER | | GOLDSBORO, NC 27534 | 4 | |
| (X4) ID PREFIX TAG | (EACH DEFICIE | Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | (EACH CORREC CROSS-REFEREN | PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIAT EFICIENCY) | |
| F 760 | Continued From p #2 signifying that t prior to 12/01/17 a correct orders. Th for the Duoneb da and no scheduled noted. Instead, Pf handwritten next to In an interview on Consultant Pharm performed the mor residents she look discharge summar the Physician Ordenew orders from th she did not review kept on their carts resident was re-act hospital all previou and the new order when she reviewe December 2017, th medications listed hours. She stated Physician Order sl | age 27 he orders had been checked nd were the most current and le computer generated order ted 11/14/17 was on the MAR times for administration were RN (as needed) was | PREFIX | administration. The medication pass obsthe administration or order. Any issues is medication pass audicorrected with retrainurse or medication Facilitator. 100% in-servicing who include nurse #1 agency nurses, was Facilitator on 5/2/20 transcribing all physinclude following ord discharge summary all medications are followed by and adminaccordance with the and will be completed. On 5/2/2018, 100% licensed nurses, to include agence. | e licensed nurse servations included of Duonebs per MD dentified during the dit was immediately ining of the license a aide by the Staff with all licensed nurse and #2, to include a initiated by the Staff 18 regarding correct sician orders, to ders from the resident care plan, and by 5/4/2018. In-service to all include nurse #1 and cy nurses and as initiated by the Staff 19 service to service to service to all include nurse #1 and cy nurses and as initiated by the Staff 19 services and as initiated by the Staff 19 services and as initiated by the Staff 19 services and 19 services an | es, ff tly ure de |
| | hours and that the orders written for the Pharmacist stated | re had been no change in he Duoneb. The Consultant that she considered not doses of Duoneb to be a | | medication administ five rights. All newl in-serviced by the S appropriate medicat including the Five R | tration to include the ly hired nurses will b staff Facilitator on tion administration, | е |
| | #2 stated that at the checked the next is most current order confirmed that she the second check | 04/26/18 at 10:40 AM M Nurse ne end of the month two nurses month's MAR to make sure the swere correctly listed. She had signed off as having done on Resident #1's December | | in orientation. All ne aides will be in-serv Facilitator on appropadministration to incorientation. | ewly hired medicatio riced by Staff priate medication clude five rights in | n |
| | | onfirmed that she did not write | | 10% of residents □ M | MARs will be review | he |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1 | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 ' ' | LE CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
|---|---|---|---------------------|--|--|--|
| | | 345113 B. WIN | | | C 04/26/2018 | |
| NAME OF PROVIDER OR SUPPLIER | | | | STREET ADDRESS, CITY, STATE, ZIP CODE | 04/20/2010 | |
| TO UNIC OF TH | TO VIDER OR OUT FEEL | | | 2401 WAYNE MEMORIAL DRIVE | | |
| WILLOW (| REEK NURSING AND I | REHABILITATION CENTER | | GOLDSBORO, NC 27534 | | |
| 0411.15 | CUIMMA DV C | FATEMENT OF DEFICIENCIES | | | TION | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO) CROSS-REFERENCED TO THE APPR DEFICIENCY) | ULD BE COMPLETION | |
| F 760 Continued From page | | e 28 | F 76 | 0 | | |
| F 760 | the scheduled administration times for the Duoneb but stated she did not write PRN next to the Duoneb order indicating it be given as needed instead of scheduled. She stated she did not know who had written PRN next to the Duoneb order. In an interview on 04/26/18 at 10:54 AM Nurse #1 stated she had transcribed Resident #1's Hospital Discharge orders to the 11/27/17 MAR but did not sign them. She indicated she did not know if another nurse had checked the orders but verified there was no second nurse signature and that another nurse should have checked the orders for errors or omissions. She indicated she had done the first check on Resident #1's December 2017 MAR and that she did not write PRN next to the medication. She indicated she had also not written the scheduled administration times for the Duoneb on the MAR. Nurse #1 indicated she did not know who had written PRN next to the Duoneb on the MAR. In a telephone interview on 04/26/18 at 3:43 PM Resident #1's Physician stated when a resident was re-admitted to the facility from the hospital he expected the hospital discharge orders to be followed. He indicated that Duoneb was a bronchodilator (used to open the breathing passages) and that missing that many doses of the ordered medication was a significant medication error. In an interview on 04/26/18 at 4:15 PM the | | F 76 | by the ADON, the QI nurse and the supervisor, to compare all physicicy orders, to include Duonebs and the discharge summary to the resident to ensure all medication orders are transcribed correctly weekly for 8 then monthly for 1 month, utilizing Medication Transcription Audit too Director of Nursing (DON) will revisinitial the Medication Transcription tool weekly for 8 weeks and then refor one month for completion and ensure all areas of concern were addressed. The QI Medication Pass Audit Too utilized by the Staff Facilitator two per week for 4 weeks; then weekly weeks; then monthly X1 month for nurses, all three shifts, to include weekends, to ensure all licensed representation and the five rights. In licensed nurse, and medication administration and the five rights. In licensed nurse, sobservation to in Nurse #1 and #2 will include administration of Duonebs per MD The DON will review and initial the Medication Pass Audit Tool for approach to the property of the pool will review and initial the Medication administration, to incluse administration of Duonebs to reside compliance weekly for 8 weeks; the weekly X4 weeks; then monthly X | an e t MAR e weeks, a l. The ew and Audit monthly to I will be times / for 4 all hurses, ude des are The nclude e order. e QI propriate de lents for len 1 | |
| | Director of Nursing (DON) stated she expected medications to be transcribed correctly from the hospital discharge summary. She indicated if there were questions she expected the nurse to call the physician to clarify the orders. She stated | | | month. Immediate retraining will be conducted for the licensed nurse, include agency nurses and/r mediaide for any identified issues observating the medication pass audits | to cation rved | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | IDENTIFICATION NUMBER: | | IPLE CONSTRUCTION IG | | (X3) DATE SURVEY COMPLETED | |
|---|---|--|---------------------|---|--|-------------------------------|--|
| | | | | | | С | |
| 345113 | | | B. WING | | | 04/26/2018 | |
| NAME OF PROVIDER OR SUPPLIER | | | | STREET ADDRESS, CITY, STATE, ZIP COL | DE | | |
| WILLOW | CDEEK NIIDSING VND | REHABILITATION CENTER | | 2401 WAYNE MEMORIAL DRIVE | | | |
| WILLOW | CILLIN HORSING AND | REHABILITATION CENTER | | GOLDSBORO, NC 27534 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CC ((EACH CORRECTIVE ACTIO) CROSS-REFERENCED TO THE DEFICIENCY) | N SHOULD BE E APPROPRIAT | | |
| F 760 | she expected two nu reconciliation of orde | urses to sign off the monthly ers and for those orders to be that that many missed doses | F 7 | Staff Facilitator. The administrator and/or the review and present the findin Medication Transcription Aud the Medication Pass Audit To Executive Quality Improveme committee monthly for 3 monissues, concerns, and/or tren will be addressed by impleme changes as necessary, to incontinued frequency of monit The Administrator and the DO responsible for the implement corrective actions to include a audits, in services, and monit to the plan of correction. | gs of the lit tool and col to the ent (QI) liths. Any ds identified enting clude coring. DN will be station of all 100% | | |